

EMPLOYEE INFORMATION				ACCIDENT/INCIDENT HISTORY			
NAME:			Z NO.:		DATE OF ACCIDENT/INCIDENT		TIME
GROUP:	MS:	WORK PHONE:	DATE OF BIRTH:	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	AREA		
OCCUPATION:				DESCRIPTION OF EVENT:			
HOME ADDRESS:				EMPLOYER:			
SUPERVISOR NAME:				PHONE:		WITNESS(ES):	
SUPERVISOR'S MS:		SUPERVISOR NOTIFIED: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE: _____			EMPLOYEE SIGNATURE:		SUPERVISOR SIGNATURE:

ERTW COORDINATOR WILL SEE INFORMATION IN THESE TWO BOXES

### ADMISSION HISTORY DATA

ALLERGIES:	LNMP:	PRESENTING HISTORY/COMPLAINT:	
	LAST TETANUS:		
CURRENT MEDS:	T BP	<b>Personal Information</b>	
	P R		
		PMD:	Interviewer's Signature:

### MEDICAL EVALUATION

TIME:	CHIEF COMPLAINT:	TESTS/TREATMENTS
SUBJECTIVE:	ERTW COORDINATOR WILL SEE INFORMATION FROM THIS POINT FORWARD	X-RAY:
		LAB:
		ECG:
		OTHER:
OBJECTIVE:		MEDS:
ASSESSMENT:		ICD - 9
PLAN:		RECHECK
		Date:
		Time:
		<input type="checkbox"/> SEE EXT. CARE SHEET

WORK RESTRICTIONS	DISCHARGE INSTRUCTIONS	DISPOSITION
<input type="checkbox"/> Limit work to _____ hours/day/week <input type="checkbox"/> No overhead work <input type="checkbox"/> No/Occ pushing/pulling <input type="checkbox"/> No driving on official business <input type="checkbox"/> No prolonged standing > _____ min <input type="checkbox"/> No/Occ lifting over _____ lbs. <input type="checkbox"/> Change positions frequently <input type="checkbox"/> Ice/heat to (R) (L) back, neck, or _____ for _____ min _____ daily for _____ days <input type="checkbox"/> No stairs, pole, ladder, or other climbing; or limit to _____ <input type="checkbox"/> Limit keyboard activity to: _____ Other: _____	<input type="checkbox"/> Wound Care <input type="checkbox"/> Back Injury <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Dermatitis <input type="checkbox"/> Fracture <input type="checkbox"/> Carpal Tunnel <input type="checkbox"/> Head Injury <input type="checkbox"/> Eye Problem <input type="checkbox"/> Upper Resp Infection <input type="checkbox"/> Gastroenteritis <input type="checkbox"/> Puncture Wound <input type="checkbox"/> Laceration <input type="checkbox"/> Other	<input type="checkbox"/> Return to work - no restriction <input type="checkbox"/> Return to work - see restrictions <input type="checkbox"/> Sent home until _____ <input type="checkbox"/> Referred for followup with _____ <input type="checkbox"/> Transferred by: _____ to: _____ <input type="checkbox"/> Private vehicle <input type="checkbox"/> Ambulance <input type="checkbox"/> LAMC ER <input type="checkbox"/> PMO

I have had the diagnosis, treatment plan, discharge instructions, and any applicable work restrictions related to this clinic visit as noted above explained to me. I understand this information and my responsibilities for cooperation and followup in my own care as outlined by the ESH-2 health care provider.

EMPLOYEE'S SIGNATURE: \_\_\_\_\_

PROVIDER'S SIGNATURE: \_\_\_\_\_

Time Out: \_\_\_\_\_